HELPING TO HEAL:

A Training on Mental Health Response to Terrorism

Field Guide

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COMING TOGETHER TO HEAL

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INTRODUCTION

This field manual is part of a larger training kit that was developed to better prepare mental health professionals and paraprofessionals for the early phases of the response to a terrorist or mass trauma event. The kit includes a CD-ROM, a manual, this field guide, and several collateral materials, such as a resource bibliography, a preparedness checklist, an "Assess your Stress" wallet card for disaster mental health workers mental health providers, and a kit feedback form.

This field guide condenses and focuses material contained in *Helping to Heal: A Training on Mental Health Response to Terrorism* (Commonwealth of Virginia Department of Mental Health, Mental Retardation and Substance Abuse Services, January 2004). It is intended to be a quick reference guide for those providing mental health services to survivors of a terrorist attack. It contains essential information, such as practical guidelines and checklists, for providing mental health services. For additional information on what is contained in the field guide, please see the *Helping to Heal* CD-ROM or manual.

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WORKING IN A DISASTER ENVIRONMENT

Conducting an Onsite Assessment

Upon arrival at the site, the disaster mental health worker is likely to meet with the setting manager and immediately be tasked with determining who needs help most. During this period, the mental health worker will be expected to set priorities; assess the environment, survivors, and workers; conduct interventions; and obtain closure. The importance of conducting a thorough and thoughtful onsite assessment is critical to the immediate and long-term mental health of those affected.

One way to conduct a rapid onsite assessment is to conduct a "defusing." This term refers to the process of helping through the use of brief conversation. Because the site will likely be somewhat chaotic, defusing as a method of onsite assessment will probably consist of short conversations in passing, perhaps in line for coffee or while eating. Defusing allows the disaster mental health worker to quickly "work the room" and assess which survivors, responders, or others might need additional support, reassurance, or information. It also provides the opportunity to assess and refer those who might need more in-depth social or mental health services. Finding unobtrusive ways to be in the vicinity of survivors and responders, such as handing out blankets or offering to get someone a soft drink, can help facilitate the defusing process and may also help a victim shift from survival mode to focusing on practical steps to restabilizing.

The following are steps to conducting a "defusing"[1]:

- **Establish rapport.** Informal socializing is appropriate, such as asking, "Can I get you a soft drink or a bottle of water?" Do not ask for an account of the survivor's experience at this point, and avoid questions or statements that might be interpreted as condescending or trivializing, such as " How are you feeling?" or "Everyone is so lucky to be alive."

- **Conduct assessments.** Assess individuals' ability and willingness to shift from their current focus to social conversation. For example, notice if individuals are so preoccupied with their own practical concerns that they are unable to engage in light conversation with others. Ask open-ended questions related to their concerns, such as "How can I help you while you're waiting for more information?" or "I'm not sure if they're letting people back into the neighborhood, but I'd be glad to see if anyone has more information." During this exchange, evaluate how individuals respond to inquiries and whether they are following the conversation.

- **Gather facts.** Fact-finding can be an efficient means of quickly determining who is most at risk due to exposure to life threat, grotesque and potentially upsetting experiences, or other traumatic stimuli. Questions such as "Where were you when it happened?" and

[1] Adapted from Young, B.H., Ford, J.D., Ruzek, J.I., Friedman, M.J., & Gusman, F.D. (1998). Disaster mental health services: A guidebook for clinicians and administrators. Menlo Park, CA: National Center for Post-Traumatic Stress Disorder, U.S. Department of Veterans Affairs.

"Were there other people with you?" also are much easier for survivors to answer at this stage than questions asking them to relay their thoughts or feelings.

- **Inquire about thoughts.** Using the description of facts that the survivors have provided, ask probing questions about their associated thoughts, such as "What were your first thoughts when it happened?" "What are you thinking now that the immediate threat is over?" "Is there anything, in particular, that you keep thinking about?"

- **Validate feelings.** Inquiring about feelings at this time is probably not appropriate. Be cautious about asking these types of questions. The defusing in this context is meant only to provide useful information to enable the mental health worker to make a rapid assessment of needs. It serves as a brief intervention that precludes in-depth exploration and ongoing support. Therefore, it is important to avoid questions that might heighten a survivor's sense of vulnerability or cause overwhelming anxiety. Look for opportunities to validate common emotional reactions and concerns, providing assurance by helping the survivor to understand typical reactions to abnormal events and situations. While helping survivors to understand the common course of traumatic reactions will not bring closure to their experience, it may give the survivor a greater sense of control and may help to prevent emotional numbing or dissociation.

- **Provide support and reassurance.** Though listed as the last step, providing support through reflective listening, dispensing information, and offering practical help should actually take place throughout the interaction. As the mental health worker moves to closure of the defusing, it is important to assess the survivor's support system to determine if a referral for social or mental health services is necessary. If a strong support system exists, emphasize the value that such social support can have in the recovery process. In addition, members of the CRP staff conveyed the idea that helping survivors recall their successful coping strategies for previously stressful experiences also was enormously helpful.

Identifying the "Leader" in a Disaster Environment

In the United States, a national response to large-scale traumatic events, such as natural disasters and acts of terrorism, is conducted through a coordinated approach involving local, state, and federal agencies. Familiarity with how a response is coordinated may be helpful in identifying who may be in charge at the site.

The Federal Response Plan (FRP) is the starting point from which all coordination decisions are made. The FRP provides for 12 Emergency Support Functions (ESF), each of which is headed by an agency that may act as the lead coordinator at a terrorism site. Mental health services fall under ESF#8, Health and Medical Services, headed by the Department of Health and Human Services (DHHS). However, other agencies may lead the effort, depending on the nature of the event. The lead agency is often unclear until officially announced.

The table below lists each function and their lead agency.

Table 1. Emergency Support Functions and Lead Agencies

Emergency Support Function	Lead Agency
ESF #1—Transportation	Department of Transportation
ESF #2—Communications	National Communications System
ESF #3—Public Works and Engineering	U.S. Army Corps of Engineers, Department of Defense
ESF #4—Firefighting	U.S. Forest Service, Department of Agriculture
ESF #5—Information and Planning	Federal Emergency Management Agency
ESF #6—Mass Care	American Red Cross
ESF #7—Resource Support	General Services Administration
ESF #8— Health and Medical Services	Department of Health and Human Services
ESF #9—Urban Search and Rescue	Federal Emergency Management Agency
ESF #10—Hazardous Materials	Environmental Protection Agency
ESF #11—Food	Food and Nutrition Service, Department of Agriculture
ESF #12—Energy	Department of Energy

Working Alongside Others

It is important to be aware of the other responders who may be present onsite. Some will perform very specific tasks, such as searching for survivors, driving ambulances, or directing traffic. Others will provide more general assistance, such as calming crowds and handing out supplies. The following table provides an idea of who those other service providers might be.

Table 2. Who Else Might Be Found Onsite

Local Response Public Agencies	• Fire and rescue department • Law enforcement • Local emergency management • Public works • Emergency medical services • Hospitals • Local officials • Survivor services • Human services
Local Response Private Agencies and Civilians	• American Red Cross • Salvation Army • Unmet Needs Committee • Community action groups • Good Samaritans • Clergy • Media • Employee assistance programs • Funeral homes
State Response	• State emergency management • State medical examiner's office • Public works • National Guard • Highway patrol • Public health • Governor's office • State attorney's office • State crime survivor compensation program • Consumer Protection Agency
***Federal Response**	• Federal Bureau of Investigation (FBI) • Bureau of Alcohol, Tobacco, and Firearms (ATF) • Office for Victims of Crime (OVC) • Federal Emergency Management Agency (FEMA) • Public Health Service (PHS) • Centers for Disease Control and Prevention (CDC) • Center for Mental Health Services (CMHS) • General Services Administration (GSA) • Small Business Administration (SBA) • Department of Veterans Affairs (VA)

*Note that many agencies are from a larger unit. CMHS and PHS, for example, are part of DHHS. Onsite, workers will probably identify themselves as being from CMHS or PHS, not DHHS.

RANGE OF REACTIONS AND APPROPRIATE INTERVENTIONS AND SERVICES

Common Reactions to Trauma

Most people experience typical reactions to terrorism and traumatic events. It is critical to reassure survivors that their reactions are normal, regardless of how they may feel. The following chart organizes, by age, typical cognitive, behavioral, physical, and emotional reactions to traumatic events.

All Ages

- ❑ Anger
- ❑ Anxiety
- ❑ Appetite changes
- ❑ Colds or flu-like symptoms
- ❑ Concentration problems
- ❑ Fear of crowds or strangers
- ❑ Fear of darkness
- ❑ Feelings of hopelessness
- ❑ Guilt
- ❑ Headaches
- ❑ Mood-swings
- ❑ Nausea/stomach problems
- ❑ Nightmares
- ❑ Poor work performance
- ❑ Confusion
- ❑ Crying easily
- ❑ Denial
- ❑ Fatigue
- ❑ Fear of being left alone
- ❑ Hyperactivity
- ❑ Hyperviligence/increased watchfulness
- ❑ Increased drug and alcohol use
- ❑ Irritability
- ❑ Isolation
- ❑ Reluctance to leave home or loved ones
- ❑ Sadness
- ❑ Sensitivity to loud noises
- ❑ Sleep difficulties

Children of All Ages

- ❑ Anxiety and irritability
- ❑ Clinging, fear of strangers
- ❑ Fear of separation, being alone
- ❑ Head, stomach, or other aches
- ❑ Increased shyness or aggressiveness
- ❑ Nervousness about the future
- ❑ Regression to immature behavior
- ❑ Reluctance to go to school
- ❑ Sadness and crying
- ❑ Withdrawal
- ❑ Worry, nightmares

Preschool Age (1–5)

- ❑ Changes in eating habits
- ❑ Changes in sleeping habits
- ❑ Clinging to parent
- ❑ Disobedience
- ❑ Fear of animals, the dark, "monsters"
- ❑ Hyperactivity
- ❑ Speech difficulties
- ❑ Regression to earlier behavior (thumbsucking, bedwetting)

Early Childhood (5–11)

- ❑ Increased aggressiveness
- ❑ Changes in eating/sleeping habits
- ❑ Difficulty concentrating
- ❑ Regression to earlier behavior
- ❑ Competing more for the attention of parents
- ❑ Fear of going to school, the dark, "monsters"
- ❑ Drop in school performance
- ❑ Desire to sleep with parents

Adolescence (12–14)

- ❑ Abandonment of chores, schoolwork, and other responsibilities previously handled
- ❑ Disruptiveness at home or in the classroom
- ❑ Experimentation with high-risk behaviors such as drinking or drug abuse
- ❑ Vigorous competition for attention from parents and teachers
- ❑ Resisting authority

Problematic Reactions

The following may indicate the need for more extensive intervention and counseling:

- ❑ Disorientation—dazed; memory loss; inability to give date or time, state where he or she is, recall events of the past 24 hours, or understand what is happening
- ❑ Inability to care for self—not eating, bathing, or changing clothes; inability to manage activities of daily living
- ❑ Suicidal or homicidal thoughts or plans
- ❑ Problematic use of alcohol or drugs
- ❑ Domestic violence, child abuse, or elder abuse
- ❑ Any common reaction may require intervention if it interferes with daily functioning

Risk Factors for Problematic Reactions to Trauma[2]

The following are risk factors at different stages of a terrorist event that may help identify individuals and groups who are more susceptible to having a more problematic stress response. Additional, immediate outreach and intervention efforts may be needed in these situations.

Personal Risk Factors Before Trauma

- Past history of Posttraumatic Stress Disorder (PSTD)
- History of childhood abuse
- Early attachment issues
- Family history of trauma
- Psychological difficulties
- History of substance abuse
- Female gender
- Younger age
- Low socioeconomic status
- Lower intelligence

[2] Adapted from presentations made by Dr. Rony Berger, Psy.D., at Natal Israel Trauma Center for Victims of Terror and War, on June 11 and 12, 2002.

Personal Risk Factors During Trauma and 24 Hours After Trauma

- Degree and intensity of exposure
- Dissociation
- Intrusion and avoidance
- Depression
- Hyperarousal
- Negative self-talk
- Lack of immediate social support

Personal Risk Factors After Trauma

- Lack of societal acknowledgment
- Lack of ongoing social support
- Stressful life events
- Unproductive family patterns

Dynamics of Symptoms Over Time

Post-event traumatic reactions may be:

- Intense or mild
- Immediate or delayed
- Cumulative in intensity
- Reactivated by:
  - Subsequent traumatic experiences
  - Reminders of the event:
    - Anniversaries
    - Area or object associated with the event (e.g., planes, building)

Symptoms may also be activated by vicarious trauma, such as media exposure or contact with people involved in the terrorist event.

Intervention Goals[3]

At the scene of a terrorist event, facilitating physical and emotional safety is the primary objective. A common response of many survivors is to feel highly vulnerable and fearful; therefore, interventions emphasize protection and safety as well as promote a sense of security. The four initial intervention goals are:

- Identify those in need of immediate medical attention
- Provide supportive assistance and protection from harm
- Facilitate connecting survivors with family and friends
- Provide information about the status of the crime scene, perpetrator(s), and immediate law enforcement efforts

Once safety is established, the following four intervention goals should be targeted:

- Alleviate distress through supportive listening, providing comfort, and empathy
- Facilitate effective problem-solving of immediate concerns
- Recognize and address pre-existing psychiatric or other health conditions in the context of the demands of the current stressor
- Provide psychoeducational information regarding post-trauma reactions and coping strategies

Overview of Interventions and Services

Immediately following a terrorist event, the primary objective of mental health interventions are to facilitate emotional stabilization. After the survivor has achieved some degree of emotional stabilization and has the ability to verbalize and process limited information, interventions should aim to alleviate distress and help with problem-solving and recovery. The following is a description of the services conducted by mental health professionals. The role of the paraprofessional is described on page 31.

Psychological First Aid[4]

Rapid assessment is conducted at the scene by mental health professionals to identify survivors who are most psychologically distressed and in need of medical attention. Initially, triage decisions are based on observable and apparent data. Persons experiencing physiological reactions such as shaking, screaming, or disorientation, may need to receive emergency medical attention. Emergency intervention involves three basic concepts: protect, direct, and connect.

[3] DeWolfe, D.J. (Ed.). (In press). Mental health response to mass violence and terrorism: A training manual. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services.
[4] Ibid.

- Survivors need to be **protected** from viewing traumatic stimuli from the event. In addition, they need to be protected from curious onlookers and the media.
- When disoriented or in shock, survivors need to be **directed** away from the trauma scene and danger, and into a safe and protected environment. A brief human connection with a disaster mental health worker can help to orient and calm them.
- Disaster mental health workers assist survivors by **connecting** them with loved ones, as well as with needed information and resources.

Psychological support involves comforting the survivor, addressing immediate physical necessities, listening to and validating feelings and stories, and other immediate needs.

Crisis Intervention[5]

While crisis intervention is somewhat similar to psychological first aid, it goes beyond the first stages of the disaster to:

- Assist survivors to regain some sense of control and mastery over their immediate situations
- Reestablish rational problem-solving abilities

An underlying assumption is that the survivor's distress and coping difficulties are due to the suddenness, horror, and catastrophic nature of the event. Crisis intervention typically involves five components:

- Promoting safety and security (e.g., finding the survivor a comfortable place to sit, giving the survivor something to drink)
- Exploring the person's experience with the disaster (e.g., offering to talk about what happened, providing reassurance if the person is too traumatized to talk)
- Identifying current priority needs, problems, and possible solutions
- Assessing functioning and coping skills (e.g., asking how he or she is doing, making referrals if needed)
- Providing reassurance, normalization, psychoeducation, and practical assistance

Informational Briefings[6]

Survivors will seek information about the location and well-being of their loved ones, levels of threat and danger, procedural information, criminal investigation updates, etc. Disaster mental health workers do not provide informational briefings, but they may consult officials about the need to do so and offer to be present during briefings to provide support as needed. Generally,

[5] Ibid.
[6] Ibid.

senior managers on the disaster mental health staff are designated to work with officials. They may offer suggestions to officials about:

- Appropriate language/terminology
- Level of detail for sensitive information
- Approaches for addressing intense emotional reactions
- Language to use in conveying messages of compassion and condolence

Psychological Debriefing[7]

Psychological debriefing is a group intervention that has been used with a wide range of groups, including emergency responders, survivors, and community groups. It involves a series of stages that move participants from a cognitive view of the event, to discussion and expression of emotions and reactions, and then back to more cognitively focused learning about coping and problem solving. Debriefings can be set up for specific groups according to need. Components of psychological debriefing consist of:

- The facilitator introducing the process and ground rules
- The participants describing the stories of their involvement with the event
- The participants describing their thoughts, feelings, and reactions during and since the event
- The facilitator validating and normalizing reactions and providing psychoeducation
- The facilitator wrapping up the session by addressing issues, distributing brochures on stress and coping, and discussing when and how to seek professional help

Brief Counseling Interventions[8]

The therapeutic goals of brief counseling interventions involve the following:

- Stabilizing emotions and regulating distress
- Confronting and working with the realities associated with the event
- Expressing emotions during and since the event, including anger, anxiety, and fear
- Understanding and managing post-trauma symptoms and grief reactions
- Developing a sense of meaning regarding the trauma
- Coming to accept that the event and resulting losses are part of one's life story

[7] Ibid.
[8] Ibid.

Support and Therapy Groups[9]

Support and therapy groups are especially appropriate for survivors of terrorist events because of the opportunity for social support through the validation and normalization of thoughts, emotions, and post-trauma symptoms. Telling one's "trauma story" in the supportive presence of others can be powerfully helpful. In addition, group reinforcement for using stress management and problem-solving techniques may promote courage and creativity. Sharing information about service and financial resources, as well as other types of assistance, is another important function of support groups. Grief counseling is an important component of group services. It is recommended that groups be facilitated by an experienced mental health professional, ideally with a co-facilitator, and be time-limited with expectations defined at the outset.

Mental Health Consultation[10]

Mental health professionals may be brought into decision-making and planning teams to advise leaders regarding mental health issues, such as mental health support and leave time for rescue and recovery workers, as well as rituals and memorials to honor the dead.

Support Role During Death Notification[11]

Mental health professionals typically do not deliver information regarding deaths but may participate on teams who accompany the person responsible for this notification. Mental health professionals provide support to the family receiving the news and, at times, to those conducting the notifications. They can also provide information to those responsible for the notification on specific cultural or ethnic customs regarding the expression of grief and rituals surrounding death and burial.

Death Notification Procedure

Mothers Against Drunk Driving (MADD) developed a curriculum on compassionate death notification for professional counselors and victim advocates. The curriculum is summarized below:

1. The coroner or medical examiner is absolutely responsible for determining the identity of the deceased.
2. Notify in person. Do not call. Do not take any possessions of the victim to the notification. If there is absolutely no alternative to a phone call, arrange for a professional, neighbor, or a friend to be with the next of kin when the call comes.
3. Take someone with you (for example, an official who was at the scene, clergy, and someone who is experienced in dealing with shock and/or trained in CPR/medical emergency). Next of kin have been known to suffer heart attacks when notified. If a large group is to be notified, have a large team of notifiers.
4. Talk about your reactions to the death with your team member(s) before the notification to enable you to better focus on the family when you arrive.
5. Present credentials and ask to come in.
6. Sit down, ask them to sit down, and be sure you have the nearest next of kin (do not notify siblings before notifying parents or spouse). Never notify a child. Never use a child as a translator.
7. Use the victim's name... "Are you the parents of _____?"

[9] Ibid.
[10] Ibid.
[11] Ibid.

8. Inform simply and directly with warmth and compassion.
9. Do not use expressions like "expired," "passed away," or "we've lost _____."
10. Sample script: "I'm afraid I have some very bad news for you." Pause a moment to allow them to "prepare." "[Name] has been involved in _____ and (s)he has died." Pause again. "I am so sorry." Adding your condolence is very important, because it expresses feelings rather than facts and invites them to express their own.
11. Continue to use the words "dead" or "died" through ongoing conversation. Continue to use the victim's name, not "body" or "the deceased."
12. Do not blame the victim in any way for what happened, even though he/she may have been fully or partially at fault.
13. Do not discount feelings, theirs or yours. Intense reactions are normal. Expect fight, flight, freezing, or other forms of regression. If someone goes into shock, have them lie down, elevate their feet, keep them warm, monitor breathing and pulse, and call for medical assistance.
14. Join the survivors in their grief without being overwhelmed by it. Do not use clichés. Helpful remarks are simple, direct, validate, normalize, assure, empower, and express concern. *Examples:* "I am so sorry." "It's harder than people think." "Most people who have gone through this react similarly to what you are experiencing." "If I were in your situation, I'd feel very _____ too."
15. Answer all questions honestly (requires knowing the facts before you go). Do not give more detail than is asked for, but be honest in your answers.
16. Offer to make calls, arrange for child care, call clergy, relatives, employer. Provide them with a list of the calls you make, as they will have difficulty remembering what you have told them.
17. When a child is killed and one parent is at home, notify that parent, then offer to take them to notify the other parent.
18. Do not speak to the media without the family's permission.
19. If identification of the body is necessary, transport next of kin to and from the morgue, and help prepare them by giving a physical description of the morgue and telling them that [Name] will look pale because blood settles to the gravitational lowest point.
20. Do not leave survivors alone. Arrange for someone to come, and wait until they arrive before leaving.
21. When leaving, let the persons know you will check back the next day to see how they are doing and if there is anything else you can do for them.
22. Call and visit again the next day. If the family does not want you to come, spend some time on the phone and re-express willingness to answer all questions. They will probably have more questions than when they were first notified.
23. Ask the family if they are ready to receive [Name's] clothing, jewelry, etc. Honor their wishes. Possessions should be presented neatly in a box and not in a trash bag. Clothing should be dried thoroughly to eliminate bad odor. When the family receives the items, explain what the box contains and the condition of the items so they will know what to expect when they decide to open it.
24. If there is anything positive to say about the last moments, share them now. Give assurances, such as "most people who are severely injured do not remember the direct assault and do not feel pain for some time." Do not say, "s(he) did not know what hit them" unless you are absolutely sure.
25. Let the survivor(s) know you care. The most beloved professionals and other first responders are those who are willing to share the pain of the loss. Attend the funeral if possible. This will mean a great deal to the family and reinforces a positive image of your profession.
26. Know exactly how to access immediate medical or mental health care should family members experience a crisis reaction that is beyond your response capability.
27. Debrief your own personal reactions with caring and qualified disaster mental health personnel on a frequent and regular basis. Do not try to carry the emotional pain all by yourself, and do not let your emotions and the stress you naturally experience in empathizing with the bereaved build into a problem for you.

Community Outreach[12]

Community outreach is an essential component of a comprehensive mental health response to acts of mass violence and terrorism. Within hours of the event, survivors and their families may be geographically dispersed. Disaster mental health workers need to consider the nature of the event and its impact, and develop a flexible plan for community outreach. Community outreach involves:

- Initiating supportive and helpful contact at sites where survivors and family members are gathered
- Reaching out to survivors through the media, the Internet, and maintaining 24-hour telephone hotlines with responders who speak different languages
- Participating in or conducting meetings for preexisting groups through faith communities, schools, employers, community centers, and other organizations
- Providing psychoeducational, resource, and referral information to health care and human service providers, police and fire personnel, and other local community workers

[12] Ibid.

SERVING DIFFERENT POPULATIONS

Assessing the potential mental health needs of different groups following a terrorist event includes a review of the three elements listed below. High levels of any of these indicate a need for monitoring and possible intervention.

- **Nature and severity of the event.** This can be assessed several ways. One obvious way is by looking at the number of casualties and the amount of property damage that result from the event. However, the level of terror and fear spread among communities and individuals may not necessarily coincide with casualties or property damage.

- **Level of exposure/proximity to the event.** Terrorism affects the entire community, but it most severely affects those who experience the event directly or those who have previously been traumatized by a terrorist-related event.

- **Group-specific vulnerabilities that could be aggravated by the event.**

The disaster mental health worker should keep in mind that, during a terrorist event, the populations often categorized as "at risk" populations may not necessarily be those most in need of mental health services. That need will largely be determined by the specifics of the terrorist event. However, the following factors may be used as considerations when attempting to identify specific populations within a community that may be adversely affected.

- Race/ethnicity
- Refugee and immigrant status
- Age
- Gender
- Religion
- Attitudes (including mental health stigmas)
- Lifestyles and customs
- Interests
- Values
- Beliefs
- Physical disability status
- Mental/emotional disability status
- Family frameworks (e.g., single-parent, blended-family, or multiple-family households)
- Income levels
- Professions and unemployment rate
- Languages and dialects
- Education and literacy levels

Providing Services to Children and Older Adults

Interventions and services need to designed and adapted to "fit" special populations. Recognizing, for example, that parents and caretakers are primary contributors to a child's recovery from trauma and bereavements, disaster mental health workers should incorporate interventions with these significant adults into a plan for children. Similarly, those intervening with elderly survivors should modify the content and format of psychoeducational materials as well as the delivery strategy for services. Disaster mental health workers should be knowledgeable about developmental differences in cognitive and emotional processing and in the daily routines that need to be reestablished.[13]

The following charts provide practical suggestions for providing services to children and older adults.

Table 4. Children's Reactions to Trauma and Suggestions for Intervention[14]

Ages	Behavioral Symptoms	Physical Symptoms	Emotional Symptoms	Intervention Options
1–5	• Clinging to parents or familiar adults • Helplessness and passive behavior • Resumption of bed-wetting or thumb sucking • Fear of the dark • Avoidance of sleeping alone • Increased crying	• Loss of appetite • Stomach aches • Nausea • Sleep problems, nightmares • Speech difficulties	• Anxiety • Generalized fear • Irritability • Angry outbursts • Sadness • Withdrawal	• Give verbal reassurance and physical comfort • Provide comforting bedtime routines • Help with labels for emotions • Avoid unnecessary separations • Permit child to sleep in parents' room temporarily • Demystify reminders • Encourage expression regarding losses (deaths, pets, toys) • Monitor media exposure • Encourage expression through play activities

[13] DeWolfe, D.J. (Draft, April 2002). Mental health interventions following major disasters: A guide for administrators, policymakers, planners, and providers. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services.
[14] DeWolfe, D.J. (Ed.). (In press). Mental health response to mass violence and terrorism: A training manual. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services.

Ages	Behavioral Symptoms	Physical Symptoms	Emotional Symptoms	Intervention Options
6–11	• Decline in school performance • School avoidance • Aggressive behavior at home or school • Hyperactive or silly behavior • Whining, clinging, acting like a younger child • Increased competition with younger siblings for parents' attention • Traumatic play and reenactments	• Change in appetite • Headaches • Stomach aches • Sleep disturbances, nightmares • Somatic complaints	• Fear of feelings • Withdrawal from friends, familiar activities • Reminders trigger fears • Angry outbursts • Preoccupation with crime, criminals, safety, and death • Self-blame • Guilt	• Give additional attention and consideration • Relax expectations of performance at home and at school temporarily • Set gentle but firm limits for acting out behavior • Provide structured but undemanding home chores and rehabilitation activities • Encourage verbal and play expression of thoughts and feelings • Listen to child's repeated retelling of traumatic event • Clarify child's distortions and misconceptions • Identify and assist with reminders • Develop school program for peer support, expressive activities, education on trauma and crime, preparedness planning, and identifying at-risk children

Ages	Behavioral Symptoms	Physical Symptoms	Emotional Symptoms	Intervention Options
12–18	• Decline in academic performance • Rebellion at home or school • Decline in previous responsible behavior • Agitation or decrease in energy level, apathy • Delinquent behavior • Risk-taking behavior • Social withdrawal • Abrupt shifts in relationships	• Appetite changes • Headaches • Gastrointestinal problems • Skin eruptions • Complaints of vague aches and pains • Sleep disorder	• Loss of interest in peer social activities, hobbies, recreation • Sadness or depression • Anxiety and fearfulness about safety • Resistance to authority • Feelings of inadequacy and helplessness • Guilt, self-blame, shame, and self consciousness • Desire for revenge	• Give additional attention and consideration • Relax expectations of performance at home and school temporarily • Encourage discussion of experience of trauma with peers, significant adults • Avoid insistence on discussion of feeling with parents • Address impulse to recklessness • Link behavior and feelings to event • Encourage resumption of social activities, athletics, clubs, etc. • Encourage participation in community activities and school events • Develop support programs for peer support and debriefing, at-risk student support groups, telephone hotlines, drop-in centers, and identification of at-risk teens

Table 5. Reactions to Trauma and Suggestions for Interventions with Older Adults[15]

Behavioral Symptoms	Physical Symptoms	Emotional Symptoms	Intervention Options
• Withdrawal and isolation • Reluctance to leave home • Mobility limitations • Relocation adjustment problems	• Worsening of chronic illnesses • Sleep disorders • Memory problems • Somatic symptoms • More susceptible to hypo- and hyperthermia • Physical and sensory limitations (sight, hearing) interfere with recovery	• Overwhelmed and shutting down • Depression • Despair about losses • Apathy • Confusion, disorientation • Suspicion • Agitation, anger • Fears of institutionalization • Anxiety with unfamiliar surroundings • Embarrassment about receiving "handouts"	• Provide strong and persistent verbal reassurance • Provide orienting information • Ensure that physical needs are addressed (water, food, warmth) • Use multiple assessment methods, as problems may be underreported • Assist with reconnecting with family and support systems • Assist in obtaining medical and financial assistance • Encourage discussion of traumatic experience, losses, and expression of emotions

Approaches for Stress Prevention and Management for First Responders

Emergency workers—police, rescue squads, firefighters—are often the first ones on the scene and the last ones out. Long hours, harsh working conditions, and a close-up view of death and destruction leave them vulnerable to intense trauma reactions.

Table 6. Approaches for Stress Prevention and Management for First Responders[16]

Dimension	Immediate Response	Longer Term Response
Management of workload	• Clarifying with immediate on-site supervisor regarding task priority levels and work plan • Recognizing that "not having enough to do" or "waiting" is an expected part of crisis mental health response • Delegating existing "regular" workload so that workers are not attempting disaster response and their usual job	• Planning, time management, and avoidance of work overload (e.g., "work smarter, not harder") • Conducting periodic review of program goals and activities to meet stated goals • Conducting periodic review to determine feasibility of program scope with the human resources available

[15] Ibid.
[16] Ibid.

Dimension	Immediate Response	Longer Term Response
Balanced lifestyle	• Ensuring nutritional eating and hydration; avoiding excessive junk food, caffeine, alcohol, or tobacco • Getting adequate sleep and rest, especially on longer assignments • Engaging in physical exercise and gentle muscle stretching when possible • Maintaining contact and connection with primary social support	• Maintaining family and social connections away from program • Maintaining (or beginning) exercise, recreational activities, hobbies, or spiritual pursuits • Pursuing healthy nutritional habits • Discouraging overinvestment in work
Stress reduction strategies	• Reducing physical tension by using familiar personal strategies (e.g., taking deep breaths, washing face and hands, meditation, relaxation techniques) • Using time off to "decompress" and "recharge batteries" (e.g., getting a good meal, watching TV, shooting pool, reading a novel, listening to music, taking a bath, talking to family) • Talking about emotions and reactions with coworkers during appropriate times	• Using cognitive strategies (e.g., constructive self-talk, restructuring distortions) • Exploring relaxation techniques (e.g., yoga, meditation, guided imagery) • Pacing self between low- and high-stress activities, and between providing services alone and with support • Talking with coworkers, friends, family, pastor, or counselor about emotions and reactions
Self-Awareness	• Recognizing and heeding early warning signs for stress reactions • Accepting that one may not be able to self-assess problematic stress reactions • Over-identifying with or feeling overwhelmed by survivors' and families' grief and trauma may result in avoiding discussing painful subjects • Trauma overload and prolonged empathic engagement may result in vicarious traumatization or compassion fatigue (Figley, 2001, 1995; Pearlman, 1995)	• Exploring motivations for helping (e.g., personal gratification, feeling needed, personal history with victimization or trauma) • Understanding when "helping" is not being helpful • Understanding differences between professional helping relationships and friendships • Examining personal prejudices and cultural stereotypes • Recognizing discomfort with despair, hopelessness, rage, blame, guilt, and excessive anxiety, which interferes with the capacity to "be" with clients • Recognizing over-identification with survivors' frustration, anger, anguish, and hopelessness, resulting in loss of perspective and role • Recognizing when own disaster experience or personal history interferes with effectiveness • Being involved in opportunities for self-exploration, and addressing emotions evoked by disaster work

EMERGENCY RISK COMMUNICATION

Working with Media Spokespersons

When approached by media during the event, the primary role of the disaster mental is to refer the media to an appropriate spokesperson.

The media can be important allies in promoting disaster mental health services and events to the community in the days following the event. Acknowledging the media's role in providing and sharing information with the public, and working to keep a cooperative relationship with them, is important. This can be accomplished by referring the media to the appropriate spokespersons, and following journalistic guidelines, such as those discussed below, when providing information about disaster mental health services and events.

Do

- Refer them to your organization's spokesperson.
- Make yourself available to them if approved by your organization.
- Realize that they decide what goes in their broadcast or publication and what they tell their audience.
- Make suggestions for the most important points to cover in the story or suggestions for other people to interview.
- Make points clear, concise, and consistent.
- Acknowledge when you do not have enough information or are unclear about something.

Do not

- Ignore them.
- Give them any information without the approval of the appropriate communication officer.
- Spoon-feed them stories or headlines.
- Dictate what you think they should put in their broadcast or publication.
- Expect that what you think is news will always be considered news by the media.

SELF-CARE FOR THE MENTAL HEALTH WORKER

When considering self-care during or after a terrorist event, it is important to examine two separate areas: emotional care and personal safety. Emotional care involves protecting one's own mental health and functioning, and personal safety refers to being aware of physical risks that one may be exposed to when involved with crisis response.

Emotional Care

Emotional care is particularly important in a terrorist situation because the disaster mental health worker may also be considered a survivor of the event. Disaster mental health workers are people too, and few people who respond to a mass casualty event remain untouched by it.

An important tool in protecting one's emotional health during a crisis is one that disaster mental health workers probably use already in their regular roles as counselors—setting personal boundaries. The boundaries that disaster mental health workers set will require a realistic assessment of their personal limits and what is needed to be effective in treating others. Keep in mind that it may be harder to maintain personal boundaries in a crisis because a disaster mental health worker also may have endured the same event, which can make it harder to remain emotionally detached. A few examples of personal boundaries that could be set include:

- Limiting exposure to media coverage
- Setting work hours (e.g., limiting shifts to 12 hours or less)
- Referring someone to another provider if the issues that come up are beyond one's expertise

Even the most experienced disaster mental health worker needs to be attentive to his or her own stress responses. Continual self-monitoring is an important component in managing stress and one's emotional health. The *Self-Monitoring Checklist* on the following pages can be used to measure stress levels following a terrorist event. Experiencing a few of the listed symptoms generally does not constitute a problem, but experiencing several symptoms from each category may indicate a need for stress reduction.

By taking care of oneself, the disaster mental health worker will be better able to care for the victims. Some stress reduction suggestions follow the checklist.

Self-Monitoring Checklist[17]

Check off anything that pertains to feelings, thoughts, or behaviors in the last 24–48 hours.

Behavioral

- ❑ I am more or less active than normal.
- ❑ I am not as effective or efficient as usual.
- ❑ People do not seem to understand what I am trying to say.
- ❑ I feel irritable or angry all the time.
- ❑ I cannot seem to rest, relax, or let down.
- ❑ I am eating a lot more/less than usual.
- ❑ I have trouble sleeping/am sleeping too much.
- ❑ I cry a lot or feel like crying all the time.
- ❑ I am drinking or smoking more than I usually do.

Physical

- ❑ My heart seems to beat fast all the time.
- ❑ I have an upset stomach, nausea, or diarrhea more often than normal.
- ❑ I have been gaining/losing a lot of weight.
- ❑ I perspire more than normal or often have chills.
- ❑ I have been having headaches.
- ❑ I have sore or aching muscles.
- ❑ My eyes are more sensitive to light.
- ❑ I have lower back pain.

[17] Carter, N.C. (Draft, 2001). Stress management handbook for disaster response and crisis response personnel. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services.

- ❑ I feel there is a "lump in my throat" all the time.
- ❑ I jump at loud noises or when people come up behind me.
- ❑ I sleep okay, but I am still tired.
- ❑ I cannot get rid of this cold/I feel I am coming down with the flu.
- ❑ My allergies, asthma, arthritis, or other chronic health condition(s) have been bothering me more than usual.

Psychological/Emotional

- ❑ I have been on a natural high/an adrenaline rush for days.
- ❑ I feel anxious or fearful often.
- ❑ I can't keep my mind on my work.
- ❑ I feel sad, moody, or depressed.
- ❑ I have been having disturbing dreams.
- ❑ I feel guilty about what the survivors are going through.
- ❑ I feel overwhelmed, helpless, or hopeless.
- ❑ I feel isolated, lost, or alone.
- ❑ No one seems to understand or appreciate me.

Cognitive

- ❑ I am having trouble remembering things.
- ❑ I get confused easily.
- ❑ I cannot figure things out as quickly as I usually do.
- ❑ I keep making mistakes or cannot make decisions well.
- ❑ I have trouble concentrating.
- ❑ I cannot quit thinking about the disaster or incident.

Social

- ❑ I do not want to be around people.
- ❑ I do not want to listen to people.
- ❑ Trying to work with the group seems like a waste.
- ❑ I just do not like to ask for help.
- ❑ People seem so slow or unresponsive.

Some Things One Can Do to Reduce Stress and Renew Energy

- Take a walk or stretch.
- Stop and breathe deeply for a few moments.
- Talk to a trusted friend about your situation.
- Eat nutritious foods (e.g., lean protein, whole grains, fruits and vegetables) and avoid sugar, caffeine, and alcohol.
- Take a hot bath.
- Read a humorous or interesting book on a topic completely unrelated to what you are dealing with.
- Sit in a dark room for a few minutes to help relieve headaches.
- Get to sleep early, if possible.
- Be patient with yourself.
- Ask people who have been through a similar experience how they handle their stress.
- Get a friend to partner with you for stress monitoring and reduction.
- If you feel lonely or isolated, ask someone to go to dinner or a movie.
- Meditate.
- Exercise.
- Spend some time with friends, family, and/or pets.
- Try to stick to your morning and/or evening routines as much as possible.

- See if shifts can be rotated with a colleague so that neither person is doing high-stress work day after day.

Personal Safety

Personal safety, especially when making home visits and when in the area of the terrorist incident, can be an issue when a disaster mental health worker responds to a terrorist event. It is important to keep safety in mind at all times and to help other team members stay safe. It is also crucial to trust one's instincts. Some possible ways to protect oneself in potentially dangerous situations include:

- Conducting outreach in teams, if possible
- Making sure to carry a cell phone and a local map
- Determining the safety of an area before going there alone
- Dressing appropriately (i.e., counselors should not stand out from the crowd)
- Checking in with supervisors, other mental health workers, and/or friends and family at pre-agreed time intervals or maintaining a daily log with arrival/departure information
- Assessing the environment (e.g., being alert for unusual or dangerous activity/persons, honoring any request to leave)
- Determining with managers, team members, and/or other mental health workers before a mental health worker starts going out into the field what situations he or she absolutely should never get into (e.g., approach a house with a big dog in the yard), what possible dangers could be encountered, and which areas should not be entered under any circumstances

Depending on the nature of the event, the disaster mental health worker also may need to monitor his or her surroundings for potential environmental dangers and be ready to evacuate the area immediately if necessary. For example, after 9/11, responders had to be aware of the possibility that damaged buildings could collapse at any time.

ROLE OF THE PARAPROFESSIONAL

What Can a Paraprofessional Do?

Paraprofessionals are generally called outreach workers, and their focus is on the secondary and tertiary victims who need support, psychoeducation, and perhaps some human services, but are not prime candidates for immediate treatment. Examples of what a paraprofessional can do include:

- Provide information and education on reactions to disasters, what survivors can expect to feel, what survivors can anticipate, and how survivors can set priorities and make plans to meet their immediate needs
- Conduct outreach in the community to determine the extent of the disaster and whether there are people or groups in the community that need assistance
- Practice supportive, or active, listening with survivors and their families
- Validate survivors' reactions and resilience stories, and affirm that their feelings are normal
- Connect survivors with their families
- Provide referrals to other social services, as appropriate
- Refer disaster survivors to other resources within the project and within the community

What Can a Paraprofessional NOT Do?

Because paraprofessionals are not trained clinicians, they cannot diagnose mental illness or provide medical services, psychological therapy, or clinical advice of any kind. Due to the range of reactions to a terrorist attack, it is critical that the paraprofessional refer the victim to a clinician for further evaluation or treatment when appropriate.

Paraprofessional Services and Interventions

This section describes services and interventions that can be conducted by mental health paraprofessionals. These include community outreach and psychoeducation.

Community Outreach

Community outreach is an essential component of a comprehensive mental health response to acts of mass violence and terrorism, and is the major role of a paraprofessional. Disaster mental health workers need to consider the nature of the event and its impact, and develop a flexible plan for community outreach.

Community outreach involves:

- Initiating supportive and helpful contact at sites where survivors and family members are gathered
- Reaching out to survivors and family members through the media and the Internet, and maintaining 24-hour telephone hotlines that are staffed with people who speak the languages spoken in the communities being served (providing services via hotlines usually requires additional training)
- Participating in or conducting meetings for preexisting groups through churches, schools, employers, community centers, and other organizations
- Providing psychoeducational, resource, and referral information to health care and human service providers, police and fire personnel, and other local community workers
- Planning activities that improve communication and understanding within communities and between cultural groups—such as cross-cultural dialogues, life skills workshops, and multicultural outreach teams

Community outreach requires:

- Ability to initiate conversations with those who have not requested services
- Good interpersonal skills
- Ability to quickly establish rapport, trust, and credibility
- Thinking on your feet
- A sense of diplomacy
- Knowledge and respect of values and practices of cultural groups impacted by the event

Psychoeducation

Psychoeducation for survivors, their families, health care providers, and providers of community services is a core component of mental health response. Information that is typically provided covers these topics:

- Typical reactions, including "normal reactions to abnormal situations"
- Grief and bereavement
- Stress management
- Effective coping strategies
- When to seek professional help

Psychoeducation may be used informally in conversation, incorporated into group presentations and as written material for widespread distribution. There is a wealth of materials available through the Center for Mental Health Services and past crisis counseling projects. Materials should be oriented specifically to the actual event and locale, and adapted for each group or population so that it is appropriate for that group. Educational presentations for parents and teachers to help them recognize children's reactions and help them cope may be offered through schools, religious organizations, and other community events. When developing written materials, consider literacy levels and the need for multiple languages.

Communicating Effectively With Survivors

Disaster mental health workers' most important tool is communication, both verbal and nonverbal. There are several major goals for the communication that paraprofessionals have with survivors.

- **Gather information**—Ask questions to understand the basic facts of a person's current situation.
- **Help clarify meaning**—Ask open-ended questions to clarify the meaning of a person's statement.
- **Provide comfort**—Listen to survivors' stories to help them work through what has happened.
- **Assist in problem solving**—Help survivors develop solutions to the practical problems they encounter as a result of the terrorist event.

The role of the paraprofessional is to provide support and assist in problem-solving—not provide psychotherapy. Using common language (not psychological jargon or bureaucratic terms) also will be very helpful in communicating with survivors.

Active Listening

The art of listening has three parts:

- Listening to and understanding nonverbal behavior
- Listening to and understanding verbal messages
- Listening to and understanding the person

Tips for employing good, active listening skills are below.

- **Paraphrase**—Rephrasing portions of what the survivor has said conveys understanding, interest, and empathy. Paraphrasing also checks for accuracy, clarifies misunderstandings, and lets the survivor know that he or she is being heard. Good lead-ins are: "So you are saying that . . ." or "I have heard you say that . . ."

- **Reflect feelings**—The paraprofessional may notice that the survivor's tone of voice or nonverbal gestures suggests anger, sadness, or fear. Possible responses are, "You sound angry, scared, etc.; does that fit for you?" This helps the survivor identify and articulate his or her emotions.

- **Allow expression of emotions**—Expressing intense emotions through tears or angry venting is an important part of healing; it often helps the survivor work through feelings so that he or she can better engage in constructive problem-solving. The paraprofessional helps by remaining relaxed and letting the survivor know that it is okay to feel that way.

- **Use nonverbal cues**—The paraprofessional can use facial expressions (e.g., smiling at appropriate times), eye contact, open body language, and head nodding to show survivors that he or she is listening and hears what they are saying.

- **Allow for silence, if appropriate**—Silence gives the survivor time to reflect and become aware of feelings and can prompt the survivor to elaborate. Some survivors will not feel like talking much. Simply "being with" the survivor can be supportive.